

Attitudes of Nursing Staff in a Maternal Child Unit Regarding Palliative Care

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### **Abstract**

**Background:** Death in the neonatal period affects not only the patient and the family, but the nursing staff. Lack of education in palliative care puts undue stress on the staff and causes negative attitudes.

**Methods and Design:** An evidence based project with a pretest, posttest, 30-day posttest design measured nurses comfort and involvement levels prior to an educational intervention, immediately after the intervention and 30-days post intervention. The sample was a convenience sample of nurses from an inpatient hospital. A psychometric instrument was used with higher scores indicating more comfort, and lower scores, indicating less comfort. This was also true for levels of involvement.

**Results:** Results from the pretest, posttest and 30-day posttest indicate there is a significant improvement in the nurse's levels of comfort. The involvement portion of the scale did not show a statistical difference, but there is a clinical significance. A possible explanation for the lack of statistical significance is that involvement is a delayed reaction to a residual effect of the intervention. There was not a statistical difference from the immediate posttest and the 30-day posttest. This indicates there may have been a lack of the ability to retain the information, or the nurses needed more time to implement what they had learned from the training.

**Conclusion:** Training and education in palliative care should be implemented for all nurses, including the maternal child staff where the mortality rate is high. The implementation of proper education can change the nurse's attitudes, comfort level and improve the overall experience of the staff, family and patient.

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### Attitudes of Nursing Staff in the NICU Regarding Palliative Care

The loss of an infant is a traumatic event that affects not only the family, but the nursing staff. Perinatal death is defined as the loss of an infant due to stillbirth, miscarriage and neonatal death (Kersting & Wagner, 2012). These deaths can be further categorized into fetal and infant deaths (MacDorman, & Gregory, 2015). Fetal mortality occurs intrauterine, infant death occurs after a live birth. In 2013, over 23,000 infant deaths occurred in the United States. Over 60% of these deaths occurred in the Neonatal Intensive Care Unit (NICU). The major causes of infant death are chromosomal abnormalities, low birth weight infants, premature infants, sudden infant death syndrome (SIDS), and accidental death (Falck, Moorthy, & Hussey-Gardner, 2016). For every 1,000 babies born every year, six of them will die (CDC, 2016).

The institution of study is a hospital that houses a maternal child unit consisting of a NICU, Labor and Deliver (L&D), Postpartum, antepartum and a Newborn Nursery. The NICU is a 49 bed, level III unit. Labor and delivery is an 11-bed unit, 9 beds are delivery beds and two are for triage. Postpartum can hold 30 patients and the newborn nursery has a capacity of 25. Antepartum is a high-risk unit that holds 10 patients. Labor and delivery averages 2,500 deliveries a year. The admissions to the NICU average 500 annually. In 2016, from January 1<sup>st</sup> to December 31<sup>st</sup>, there were 471 admissions to the NICU with 13 deaths. The causes of death were prematurity, sepsis, hypoxic-ischemic encephalopathy, and chromosomal abnormalities. In L&D, there were multiple fetal deaths.

Due to the high mortality rates in the fetal and neonatal period, it is pertinent that palliative and bereavement care education is provided and placed in to practice (Falck, Moorthy, & Hussey-Gardner, 2016). Palliative care has a goal of preventing pain and distress, while providing comfort and support to the family and patient. Those who qualify for palliative care have conditions that are incompatible with life, a high risk of death, on life support, and those

experiencing unbearable suffering (Twamley et al., 2012).

Many hospital systems do not have a palliative care/bereavement care program in place. Education is lacking in this area and it starts with lack of training in nursing school. There is “little known about the impact and implementation of palliative care practices in the NICU and palliative care remains underutilized in neonates” (Younge et al., 2014. p 218). The lack of palliative care and bereavement training that is provided to nursing staff is inexcusable. Nursing staff who provide care for the dying infant are at risk for moral distress without proper training (Chen et al., 2012). Their attitude regarding palliative care is essential in providing the best care possible for the patient and their family. If nurses are educated regarding palliative and bereavement care, their attitude, comfort level, and perceptions are changed to provide a more positive experience during a devastating time (Chen et al., 2012).

### **Review of Literature**

There were six articles that were analyzed on palliative care education and attitudes, nurses comfort levels and barriers to providing care. The term “attitudes” as described by Chen et al. (2012) is a way of describing one’s feelings, both positive and negative. The consensus of all six articles was further education, policies and protocols were needed to improve the attitudes of staff regarding palliative care.

Educational interventions improve nurses comfort levels in relation to palliative care. Attitudes and beliefs present obstacles in providing palliative care if one is not properly trained and educated (Chen et al., 2012). Chen et al. (2012) conducted a study to explore nurse’s attitudes and beliefs towards dying neonates. The study concluded a lack of policy, guidelines and counseling, negatively affect the staff and the patient (Chen et al., 2012). Knapp et al. (2011) found that providing education on palliative care to nursing staff would improve the patient’s

overall quality of life and staff comfort level. Nurses who have had previous training have a more positive overall attitude and less discomfort (Chen et al., 2012; Knapp et al., 2011). While most participants in the studies had positive outlooks in regards to providing end-of-life care, both were adamant in recommending education on palliative care for nursing staff to provide the patient with the best quality of life (Knapp et al., 2011; Chen et al., 2012).

Four of the studies implemented an educational training program to improve the overall attitudes of the nurses and increase the level of job satisfaction (Murakami et al., 2015; Rogers, Bagbi and Gomez, 2008; Twamley et al., 2015; Zhang & Lane, 2013). One study was a bereavement seminar, two were educational workshops and one was a one-hour educational session. The participants of the educational interventions found that education implementation improved communication, resolved ethical issues, increased family support, more positive attitudes and improved overall comfort level (Murakami et al., 2015; Rogers, Bagbi and Gomez, 2008; Twamley et al., 2015; Zhang & Lane, 2013). The interventions reiterated what Chen et al. (2012) and Knapp et al. (2011) found in their study, which was- the goal of palliative care is to provide the best quality of life while respecting the patient.

The lack of education regarding palliative care not only decreases morale of the staff, it does not allow the patient to receive the care they are entitled. Forming interdisciplinary teams that consist of educated staff, comfortable with palliative care, will improve patient and family satisfaction (Cavinder, 2014). Kain et al. (2013), also concludes that education of palliative care is lacking which in turn affects the attitudes and comfort levels of the staff. There are many barriers to providing appropriate palliative care such as attitudinal, educational, lack of institutional support and training. While the suggestions of changing the practice of palliative care include following models, forming interdisciplinary teams, or providing educational

interventions, the overall consensus is there needs to be a change to break down the barriers that are standing in the way of providing exceptional care to this population while improving the comfort level and attitudes of the staff (Cavinder, 2014, Chen et al., 2012, Kain et al., 2013 and Knapp et al., 2011).

### **Project Framework**

The framework of focus is Palliative care (supportive and end of life care). This framework consists of steps A-H. For this project, steps A-C will be the focus (see *Appendix A*). Step A, is to establish eligibility of the fetus or baby for palliative care. Step B is family care and step C is communication and documentation. Step A allows the staff to determine who is eligible for palliative care. The diagnosis and prognosis of the patient should be discussed with specialists to determine whether the patient is a candidate for palliative care. Step B is family focused (British Association of Perinatal Medicine, 2010). It is essential that the staff understand the meaning and need for palliative care. They must have proper training to provide the appropriate information to the family. The training sessions will allow for this step to be a positive experience for the staff and the family. The staff will be able to provide emotional support and help the family make memories with their loved one (British Association of Perinatal Medicine, 2010). Step C involves communication with the multidisciplinary teams. This focuses on all staff being on the same page throughout the palliative care process. The plan of care should be documented and clearly stated so that all parties understand the desires of the family (British Association of Perinatal Medicine, 2010). Steps D-H focuses on direct patient care which is not the focal point of this project.

### **PICO Question**

In maternal child (Labor and Delivery, NICU, antepartum, postpartum and Newborn



Nursery) nurses, does implementing education on palliative care compared to no education, affect the attitudes and comfort level regarding end of life care?

### **Objectives**

- Improve attitudes of nurses regarding palliative care
- Increase general knowledge of palliative care
- Improve overall comfort level of providing palliative care

### **Methods**

#### **Project Design**

The EBP project used a pretest/posttest/30-day posttest evaluation. Prior to educational training, staff members took a pretest to evaluate their attitudes and knowledge of palliative care. The posttest evaluated knowledge of palliative care and attitudes immediately following the educational training. The 30-day posttest was a re-evaluation of the knowledge and attitudes after the nursing staff had time to implement the training in to practice.

#### **Population/Setting**

The setting for the educational intervention was a maternal child department at an inpatient hospital. The maternal child department consisted of the neonatal intensive care unit (NICU), labor and delivery (L&D), antepartum, postpartum and newborn nursery. There are over 175 nurses that make up the maternal child unit. All departments work in conjunction with one another. Staff nurses from each of these departments float to other units to cover when needed. This was the determining factor for including the entire department in the educational training.

The inclusion criteria were registered nurses (RN), licensed vocational nurses (LVN) and advanced practice registered nurses (APRN) who work in the NICU, L&D, antepartum, postpartum and newborn nursery. Individuals were excluded were physicians, and other support

staff such as respiratory therapists and the unit secretary.

### **Measurement Methods**

The Bereavement/End of life Attitudes About Care of Neonatal Nurses Scale (BEACONNS) is the instrument used for the pretest/posttest questionnaire. Permission was granted by Dr. Arthur Engler for use of this instrument, see *Appendix B*. There are three parts to the BEACONNS scale. The first is a brief assessment on information and beliefs about bereavement/end-of-life care. The second part is level of comfort. The third focuses on factors influencing involvement with families. The comfort level and factors influencing involvement with families were used for this project. The comfort level section contains 19 items that focus on the nurse's perceptions of end of life care and their comfort level of providing care to their patients, see *Appendix C* (Engler et al., 2004). The 19 questions are on a Likert scale, ranging from very comfortable (5) to very uncomfortable (1). The section on factors influencing involvement with family consists of a 14 question Likert scale ranging from very important (5) to very unimportant (1), see *Appendix D* (Engler et al. 2004). Zhang and Lane (2013) report the reliability for the comfort portion of the scale has a Chronbach's Alpha of 0.95 and the involvement scale's reliability as 0.85. In addition to the BEACONNS instrument, a questionnaire including demographics, nursing experience with death, and nursing education, was given see *Appendix E*.

### **Data Collection/Implementation Plan**

Implementation of the palliative care educational training, consisted of a neonatal nurse practitioner (NNP) attending a Resolve Through Sharing® training to further her education in palliative care. Resolve Through Sharing® is an evidence-based compassionate approach to bereavement care. This training prepares healthcare providers with the capability of providing

excellent bereavement care, learning best practices and gaining a foundation of knowledge of death and dying (Resolve Through Sharing, 2017).

Resolve Through Sharing ® prepared the attendee with information to train other staff members at their home facility. The objectives and information taught at the training consisted of relationship roles, understanding grief, self-care and caring for other healthcare providers, and general evidence-based information in bereavement care (Resolve Through Sharing, 2017).

Once the preparations for the educational training was established, attendance dates and times for nursing staff were posted throughout the maternal child units see *Appendix F*. The nursing staff also received e-mails from the unit directors with information regarding the training times and dates. There were two rotations on night shift and two rotations on day shift. Training times were scheduled to accommodate each shift. The sessions were scheduled for an hour. While the training was not mandatory, CEU's were offered for attendance. The nurse educator for the hospital completed the CEU specifications.

Prior to the training, the staff filled out a demographics form, see *Appendix E*, and completed a pretest regarding attitudes, beliefs and basic knowledge of palliative care. There was a sign in sheet provided where they recorded their information for continuing education hours. Their names on the sign in sheet were used to track who attended class for the 30-day posttest. Resolve Through Sharing ® coordinator training provides the educator (NNP) with a PowerPoint regarding perinatal palliative care, speaker notes, demonstration videos and guided participation activities, see *Appendix G* (Resolve Through Sharing, 2017). The information obtained from the coordinator training was compiled to meet the needs of the educational session offered. After the training was completed, the staff completed a posttest immediately after. Thirty days after the initial training, a second posttest was given to the staff who attended to determine whether their

attitudes and new knowledge had any further change. The pretest and posttest were anonymous with no identifying factors present. The pretest and posttest consisted of the BEACONNS scale. The information was stored in a locked filing cabinet. Due to the nature of the project, IRB approval was not required from The University of Texas Arlington or from the training hospital, see *Appendix H* and *Appendix I*.

### **Data Analysis**

SPSS software was used for statistical analysis. The Kruskal Wallis Test was used for statistical analysis of the pretest/posttest/30-day posttest evaluation. The test was conducted to determine whether the educational teaching influenced nurse's attitudes and comfort levels and to determine whether it's clinically or statistically significant immediately after (POST) and 30 days after (POST\_30). The statistical comparison evaluated the difference, in a multi-way exhaustive post hoc comparison, between the pretest, posttest, and 30-day posttest, group test scores. The threshold for statistical significance and rejection of the Null Hypothesis was set at the level of (95% Confidence,  $p < 0.05$ ). Summative test scores were developed for each part of the BEACONNS scale (see *Appendices C and D*) and these were combined as a total sum score of Involvement and Comfort. The groups were classified as Comfort and Involvement. A total score was combined (Involvement and Comfort). For Comfort Score, the Null hypothesis is rejected (there is no significant differences among pre, post, or 30-day post) test scores (Kruskal-Wallis,  $N = 97$ ,  $KW = 15.387$ ,  $df = 2$ ,  $p < 0.05$ ). Exhaustive post hoc comparison of mean ranks of distributions found that scores were significantly higher at post intervention compared to pre-intervention ( $p < 0.05$ ) and were also significantly higher in the 30-day post intervention ( $p < 0.05$ ), yet were not significantly different between post and 30-day post test scores, see *Appendix J*. The Involvement score was not statistically significant. The Null hypothesis is

retained (there is no significant differences among pre, post, or 30-day post) test scores (Kruskal-Wallis, N 97, KW 4.480, df 2,  $p < 0.05$ ). No post hoc tests were performed see *Appendix K*. The Involvement score was not statistically significant at 95% confidence, yet the p value was 0.106. This value is near 90% confidence and although not significant at the level of 95% confidence it does indicate that the scores were progressively and measurably higher in post and 30-day post groups, indicating clinically significant quality improvement, even if not within the statistically significant threshold tested, see *Appendix K*. For Total Score (Comfort and Intervention combined), the Null hypothesis is rejected (there is no significant differences among pre, post, or 30-day post) test scores (Kruskal-Wallis, N 97, KW 12.205, df 2,  $p < 0.05$ ). Exhaustive post hoc comparison of mean ranks of distributions found that scores were significantly higher at post intervention group compared to pre-intervention ( $p < 0.05$ ), and were also significantly higher at 30-day post intervention ( $p < 0.05$ ), yet were not significantly different between post and 30-day post test scores, see *Appendix L*.

## **Results**

A total of 36 nurses participated in the project. The majority (97%) were NICU nurses. One nurse was the Director of Maternal Services. The participant's formal education included associate's degree (67%), bachelor's degree (29%), and master's degree (3%). Nursing experience ranged from less than one year to greater than 20 years. More than half of the participants had less than 10 years of experience (56%) and the remaining participants had 10 years to greater than 20 years of experience (44%). Eighty percent have provided care for dying infants or families that had experienced pregnancy loss. Sixty four percent had end of life/bereavement care in their nursing education, and only a fourth (27%) have had continuing educations since then.

Results from the pretest, posttest and 30-day posttest indicate that there is a significance in improvement of nurse's levels of comfort, statistically and clinically. The involvement portion of the scale did not show a statistical difference, but there is a clinical significance. A possible explanation for lack of statistical significance is that involvement is a delayed reaction to a residual effect of the intervention. The POST and POST\_30 day scores were not statistically significant. This indicates there may have been a lack of the ability to retain the information, or the nurses needed more time to implement what they had learned from the training. Two additional questions were added at the end of the first pretest for further assessment of the educational session, see *Appendix M*. The first question asked the staff if they would like to receive additional training. Eighty six percent of them said yes. The second question asked if they found the training helpful. One hundred percent said yes. While these questions were not included in the statistical analysis, it is pertinent information relaying the need for further education.

### **Discussion and Conclusion**

This project has limitations. The sample size was small, making the generalizability of the project questionable. Also, every participant works in the same hospital, in the same NICU. The educational sessions were one hour long, which is not long enough to cover all the information needed to promote a positive change. Also, multiple participants left questions blank on their questionnaires. There were participants who did not complete the 30-day posttest due to change of job, maternity leave and failure to turn the survey in. The biggest threat to validity was seasonal variation. In the future, a bigger sample size over a longer period of time will increase the generalizability and validity.

Further research is indicated regarding palliative care interventions for staff nurses. Moral

distress, positive and negative feelings, and comfort level have all been shown to improve with implementing learning opportunities for the staff (Rogers, Bagbi and Gomez, 2008; Twamley et al., 2015; Zhang & Lane, 2013). Knowledge deficits regarding palliative care are unhealthy for the staff, the patient and their families. Further research is needed regarding the change in health care professional's perceptions of palliative care.

Nurses who are providing palliative care should be qualified and specially trained (Get Palliative Care, 2016). The lack of training in palliative care has repeatedly been shown in research. Training and education in palliative care should be implemented for all nurses, including the maternal child staff where the mortality rate is high. The implementation of proper education can change the nurse's attitudes, comfort level and improve the overall experience of the staff, family and patient (Zhang & Lane, 2013).

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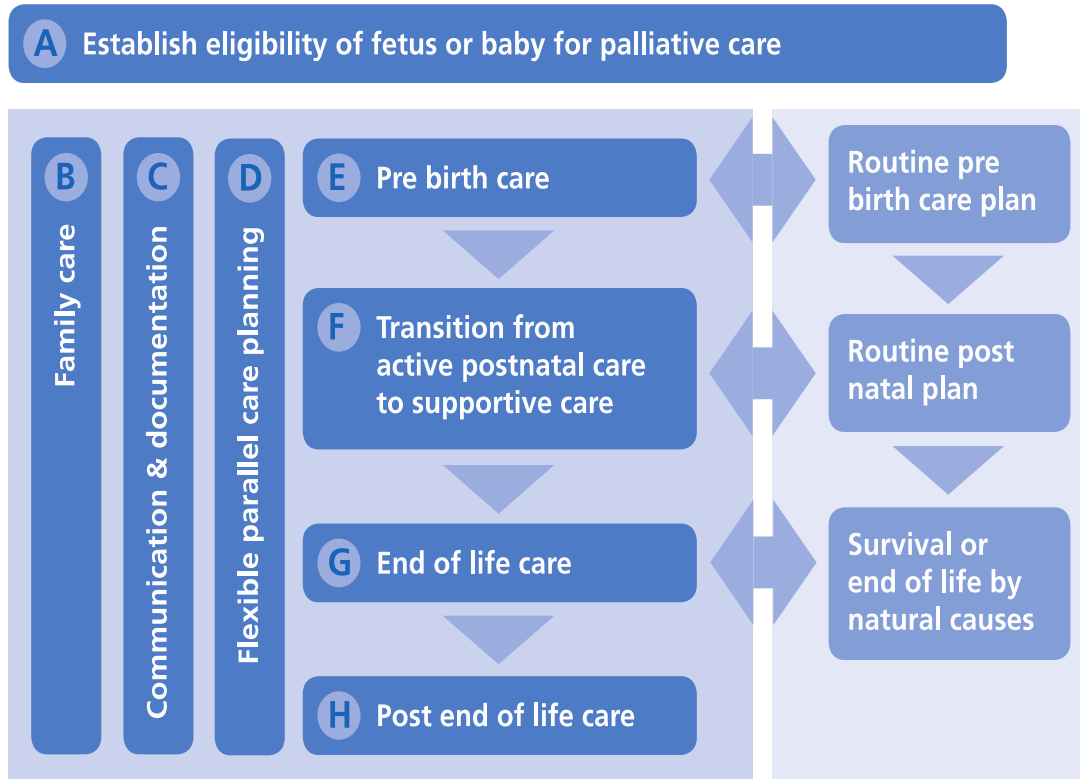
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**Appendix A**

Stages of palliative care planning



*Figure 1.* Diagram of Palliative care (supportive and end of life care) framework. (British Association of Perinatal Medicine, 2010).

### Appendix B

Re: Bereavement End-of-Life Attitudes About Care - McAnear, Lindsey Feemster

2/26/18, 10:26 AM

## Re: Bereavement End-of-Life Attitudes About Care: Neonatal Nurses Scale

Engler, Arthur [REDACTED]

Sat 2/25/2017 12:45 PM

Inbox

To: McAnear, Lindsey Feemster [REDACTED]

Of course you can use the scale. Just give us an acknowledgement in any pubs. Good luck?

Art

PS do you need a copy of the too?

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**From:** McAnear, Lindsey Feemster [REDACTED]  
**Sent:** Saturday, February 25, 2017 12:01:54 PM  
**To:** Engler, Arthur  
**Subject:** Bereavement End-of-Life Attitudes About Care: Neonatal Nurses Scale

Dr. Engler,

My name is Lindsey McAnear. I am a Neonatal Nurse Practitioner. Currently, I am a DNP student at the University of Texas Arlington. My DNP project is looking at attitudes and comfort levels of staff nurses regarding palliative care. I would like permission to use your Bereavement End-of-Life Attitudes About Care: Neonatal Nurses Scale for my project. I plan on implementing an educational training course to the staff and evaluating their comfort level, attitudes and general knowledge of palliative care. The study will be a pretest/post test design. Thank you for your consideration. If you have any further questions for me, please let me know.

Thank you.

Lindsey McAnear MSN, RN, NNP-BC

## Appendix C

### Level of Comfort

Please circle the number that corresponds to the degree of comfort you feel with each of these aspects of bereavement/end-of-life care.

	5= Very Comfortable	4= Comfortable	3= Neither Comfortable Nor Uncomfortable	2= Uncomfortable	1= Very Uncomfortable
1. Allowing families to hold their dying or dead infant	5	4	3	2	1
2. Allowing families to participate in post-mortem care of their infant	5	4	3	2	1
3. Appropriately touching grieving family members as a way of showing your care and concern.	5	4	3	2	1
4. Assisting families in experiencing the pain of grief	5	4	3	2	1
5. Caring for the family of a dying infant	5	4	3	2	1
6. Contacting families after their infant has died in your unit	5	4	3	2	1
7. Discussing autopsy or organ donation with families of dying infants	5	4	3	2	1
8. Discussing funeral arrangements with families	5	4	3	2	1
9. Discussing withdrawal of life support or therapy with families	5	4	3	2	1
10. Dressing the dying/dead infant rather than leaving them nude or covering them with just a blanket	5	4	3	2	1
11. Families who cry are otherwise verbal around the time their infant is dying	5	4	3	2	1
12. Getting together with other staff members who cared for a deceased infant to share food, talk about the death, and discuss your reactions to it	5	4	3	2	1

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	5= Very Comfortable	4= Comfortable	3= Neither Comfortable Nor Uncomfortable	2= Uncomfortable	1= Very Uncomfortable
13. Helping peers learn to provide culturally sensitive and competent bereavement/end-of-life care	5	4	3	2	1
14. Participating in closure or grief conferences with families and other caregivers following the death of an infant	5	4	3	2	1
15. Providing culturally sensitive bereavement/end-of-life care for families of cultures other than your own	5	4	3	2	1
16. Providing post-mortem care for your patients	5	4	3	2	1
17. Sitting with parents and listening as they express their grief	5	4	3	2	1
18. Talking to families about grief and bereavement issues	5	4	3	2	1
19. Talking to friends of the deceased infants family about the grief process and what to expect	5	4	3	2	1

The Level of Comfort Likert scale questionnaire is the first part of the BEACONNS scale (Engler, 2004).

## Appendix D

### Factors Influencing Involvement with Families

Please circle the number that corresponds to how important you believe each of these

	5= Very Important	4= Important	3= Neither Important Nor Unimportant	2= Unimportant	1= Very Unimportant
1. A busy unit	5	4	3	2	1
2. A dying infant	5	4	3	2	1
3. A family being supported by others	5	4	3	2	1
4. A family whose infant has just died	5	4	3	2	1
5. A receptive family	5	4	3	2	1
6. Expectations of nursing leaders in your unit and/or hospital	5	4	3	2	1
7. Expectations of your peers	5	4	3	2	1
8. When there is a language or cultural barrier between you and the family	5	4	3	2	1
9. When you are dealing with a very young parent	5	4	3	2	1
10. When you are unsure of what information the physician or advanced practice nurse has given the family	5	4	3	2	1
11. When you are unsure of your nursing skills in a particular case	5	4	3	2	1
12. When you disagree with the treatment your patient is receiving	5	4	3	2	1
13. Your feeling supported by other people	5	4	3	2	1
14. Your own high stress level	5	4	3	2	1

The Factors Influencing Family Involvement is a portion of the BEACONNS scale (Engler, 2004).

## Appendix E

### Demographic Information

Please circle your answer.

1. Which of the following is considered your home department?
  - a. Neonatal Intensive Care Unit
  - b. Newborn Nursery
  - c. Labor and Delivery
  - d. Post-Partum
  - e. Ante-Partum
  
2. Did the nursing program you attended offer information/content regarding bereavement care?
  - a. Yes
  - b. No
  
3. Have you had continuing education in bereavement care?
  - a. Yes
  - b. No
  
4. How often do you care for dying infants?
  - a. Never
  - b. Less than once a year
  - c. At least once every six months
  - d. At least once every three months
  - e. At least once a month
  - f. At least once a week
  
5. How many years of nursing experience do you have?
  - a. <1 year
  - b. 1-3 years
  - c. 3-5 years
  - d. 5-10 years
  - e. 10-15 years
  - f. 15-20 years
  - g. >20 years
  
6. What is your highest level of education in nursing?
  - a. Associate's Degree
  - b. Bachelor's Degree
  - c. Master's Degree
  - d. Doctoral Degree
  
7. What is your title?
  - a. Licensed Vocational Nurse
  - b. Registered Nurse
  - c. Advanced Practice Registered Nurse
  - d. Other:\_\_\_\_\_



Appendix F

# Bereavement Training in Perinatal Death



**What:**

One (1) contact hour

**When: (attend one session only)**

October 11, 2017; 12:00 pm @ East Campus Conference Room

October 17, 2017; 5:30 pm @ East Campus Conference Room

October 17, 2017; 7:30 pm @ East Campus Conference Room

November 13th, 2017; 7:30 pm @ East Campus Conference Room

## Appendix G

# *Objectives*

- Describe a theoretical framework of attachment, loss, and grief
- Identify responses to loss
- Discuss what bereaved families find helpful and hurtful
- Explain the value of an interdisciplinary approach to supporting families



## Appendix H

### **DNP Project Approval Template for the Graduate Nursing Department Review Committee**

#### **Student completes the top portion only**

Student ID number: 1001275308

Project Title: Attitudes of Nursing Staff in a Maternal Child Unit Regarding Palliative Care

Project Summary (Brief): Death in the fetal and neonatal period affects not only the patient and the family, but the nursing staff. Nursing staff who provide care for the dying infant are at risk for moral distress without proper training. Lack of education in palliative care puts undue stress on the staff and causes negative attitudes providing bereavement care (Chen et al., 2012). There will be a training provided to the nursing staff. This will be a pretest/posttest design. There will be a posttest immediately following the training and one 30 days after to assess attitudes and comfort level after an educational training.

Reference:

Chen, C., Huang, L., Liu, H., Lee, H., Wu, S., Chang, Y., Peng, N. (2012). To explore the neonatal nurses' beliefs and attitudes towards caring for dying neonates in Tawaiian. *Maternal Child Health Journal (2013)* 17, pp 1793-1801. Doi:10.1007/s10995-012-1199-0

Setting: Maternal Child Unit in an inpatient hospital.

Population: Staff nurses who work in a maternal child unit.

The project will use the following model (i.e. PDSA, IOWA etc):

The framework of focus is Palliative care (supportive and end of life care).

#### **Committee Use Only**

The results will be disseminated, but they are not generalizable knowledge. The results will include use of the most current research to translate the knowledge into practice, thus it is not new generalizable knowledge.  Agree  Disagree

This project is a quality improvement  or evidence-based project  and will translate the knowledge into the clinical setting. It is not generalizable because it is not generated from a research study that is being conducted.

Yes  No This project is not considered Human Subjects Research and does not require IRB HSR review.

This quality improvement project did not satisfy the *definition of research* under 45 CFR 46.102(d). Therefore, it was not subject to the Health and Human Services regulations for the

GNRC Form 1: January, 2017

protection of human subjects in research (45 CFR part 46, 2009) or require Institutional Review Board approval.

I recommend approval of this QI project

I recommend approval of this EBP project

or

I do not recommend approval of this project for the following:

I recommend the student send this project to the University IRB for review

Reason:

I do not recommend this project to be implemented

Reason:

  
Committee Member Signature

6/7/2017  
Date

### Appendix I

Fw: DNP project - Lindsey McAnear

3/5/18, 12:07 PM

## Fw: DNP project

[Redacted]

Mon 1/22/2018 8:23 AM

Inbox

To: Lindsey McAnear [Redacted]

This is the email from [Redacted] Hope this helps.

Thanks!

[Redacted]

[Redacted]

NOTICE: This email may contain PRIVILEGED and CONFIDENTIAL information and is intended only for the use of the specific individual(s) to which it is addressed. It may contain Protected Health Information that is privileged and confidential. Protected Health Information may be used or disclosed in accordance with law and you may be subject to penalties under law for improper use or further disclosure of the Protected Health Information in this email. If you are not an intended recipient of this email, you are hereby notified that any unauthorized use, dissemination or copying of this email or the information contained in it or attached to it is strictly prohibited. If you have received this email in error, please delete it and immediately notify the person named above by reply email. Thank you.

----- Forwarded by [Redacted] on 01/22/2018 08:22 AM -----

From: [Redacted]  
To: [Redacted]  
Cc: [Redacted]  
Date: [Redacted]  
Subject: Re: Fw: DNP project

I just met with Lindsey and I feel it would be a great service for all. I am going to share if you did not already know I had a grand daughter who passed on Easter morning 7 years ago. The staff did impact me back then on my decision to accept this job here because of the great compassion and time they spent helping us through this journey. I know this will help them as well because it has to be trying like any nursing role with loss.

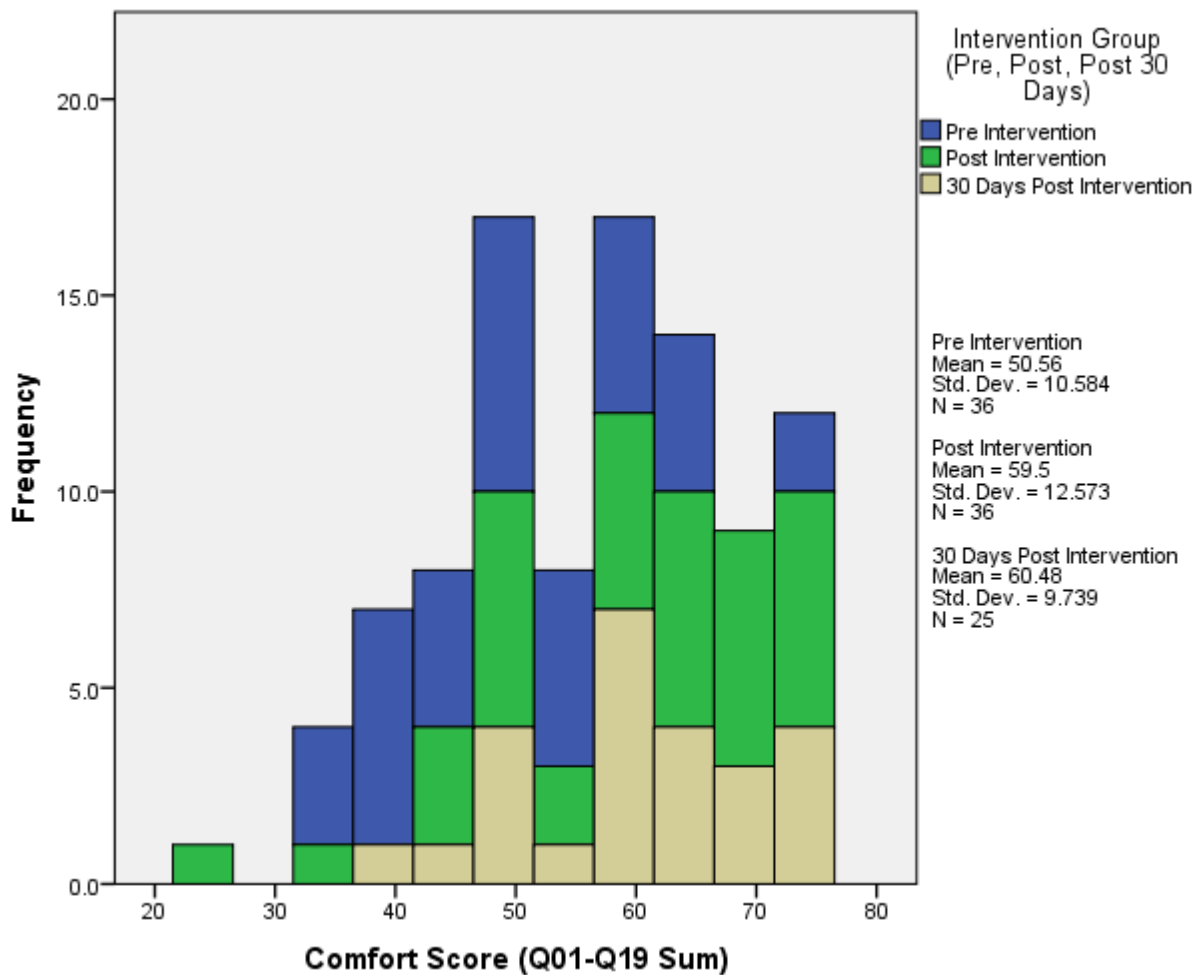
[Redacted]

**Appendix J**

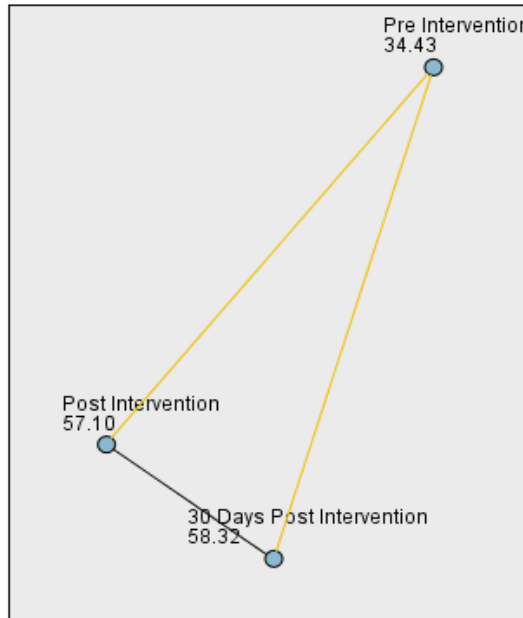
**Hypothesis Test Summary**

	<b>Null Hypothesis</b>	<b>Test</b>	<b>Sig.</b>	<b>Decision</b>
<b>1</b>	The distribution of Comfort Score (Q01-Q19 Sum) is the same across categories of Intervention Group (Pre, Post, Post 30 Days).	Independent-Samples Kruskal-Wallis Test	.000	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.



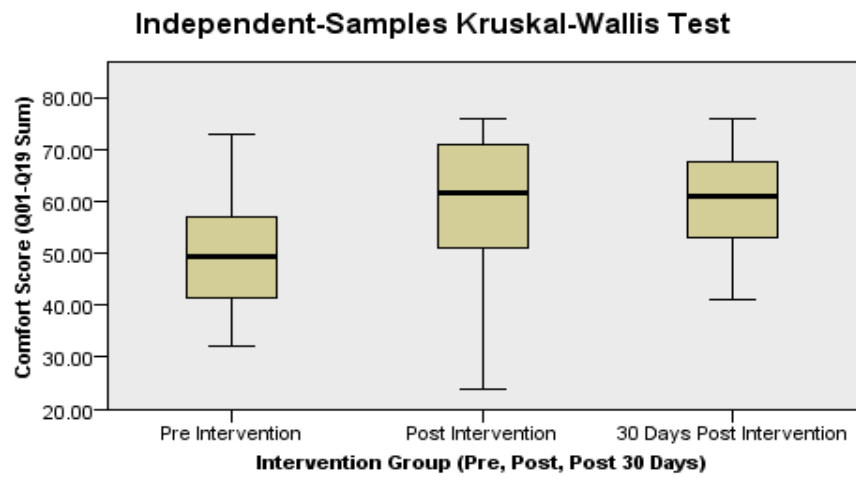
**Pairwise Comparisons of Intervention Group (Pre, Post, Post 30 Days)**



Each node shows the sample average rank of Intervention Group (Pre, Post, Post 30 Days).

Sample1-Sample2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj.Sig.
Pre Intervention-Post Intervention	-22.667	6.630	-3.419	.001	.002
Pre Intervention-30 Days Post Intervention	-23.889	7.323	-3.262	.001	.003
Post Intervention-30 Days Post Intervention	-1.223	7.323	-.167	.867	1.000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) are displayed. The significance level is .05.



<b>Total N</b>	97
<b>Test Statistic</b>	15.387
<b>Degrees of Freedom</b>	2
<b>Asymptotic Sig. (2-sided test)</b>	.000

1. The test statistic is adjusted for ties.

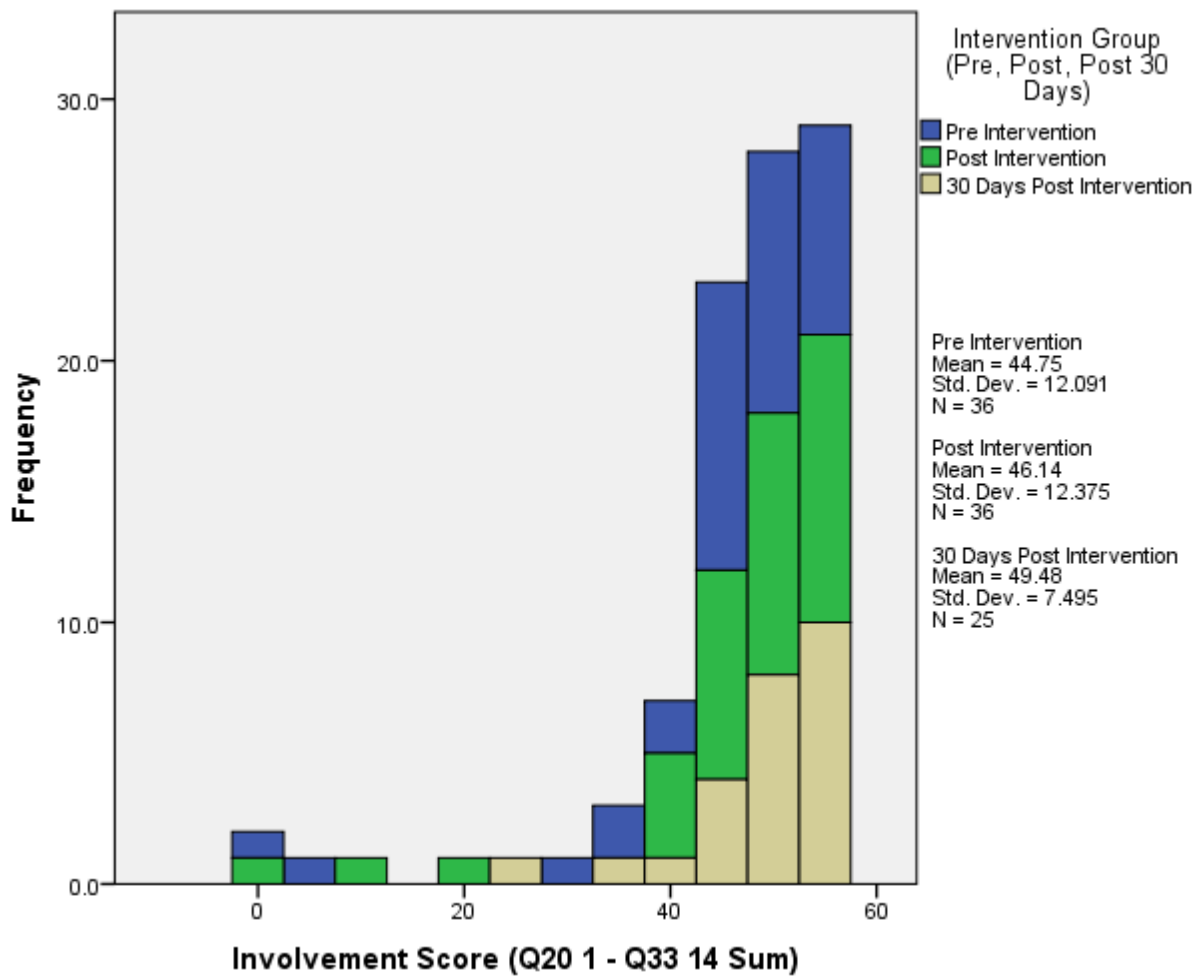


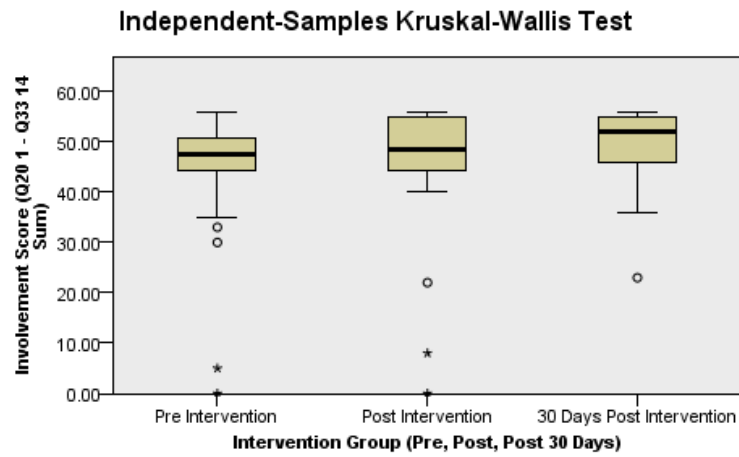
### Appendix K

#### Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of Involvement Score (Q20 1 - Q33 14 Sum) is the same across categories of Intervention Group (Pre, Post, Post 30 Days).	Independent-Samples Kruskal-Wallis Test	.106	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.





<b>Total N</b>	97
<b>Test Statistic</b>	4.480
<b>Degrees of Freedom</b>	2
<b>Asymptotic Sig. (2-sided test)</b>	.106

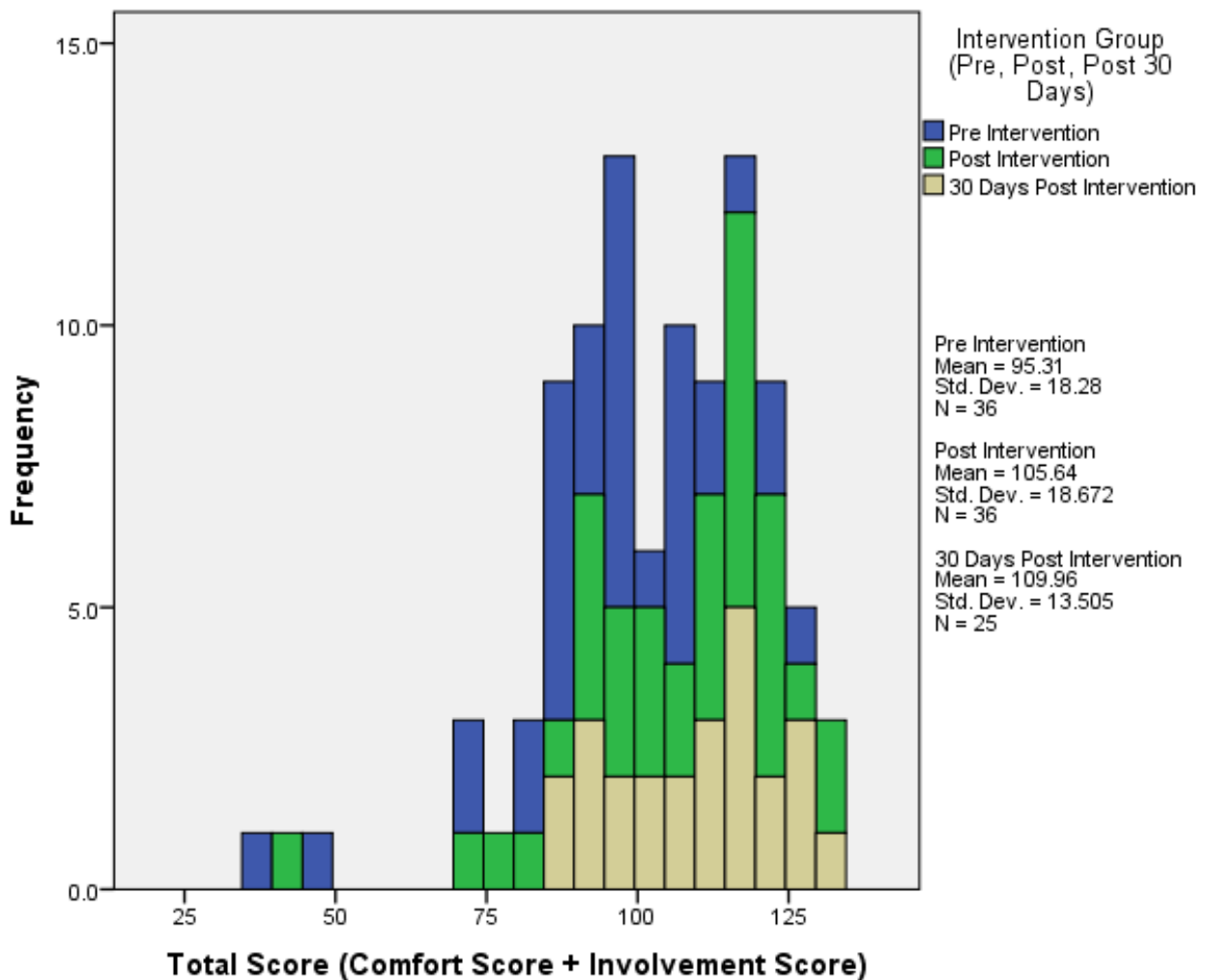
1. The test statistic is adjusted for ties.
2. Multiple comparisons are not performed because the overall test does not show significant differences across samples.

Appendix L

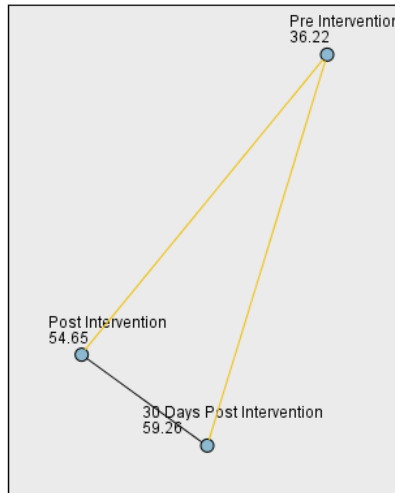
Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of Total Score (Comfort Score + Involvement Score) is the same across categories of Intervention Group (Pre, Post, Post 30 Days).	Independent-Samples Kruskal-Wallis Test	.002	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.



**Pairwise Comparisons of Intervention Group (Pre, Post, Post 30 Days)**

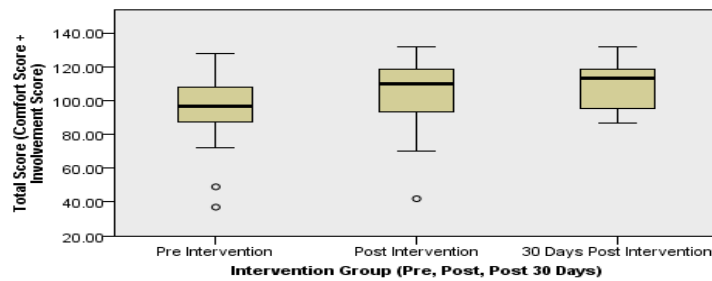


Each node shows the sample average rank of Intervention Group (Pre, Post, Post 30 Days).

Sample1-Sample2	Test Statistic	Std. Error	Std. Test Statistic	Sig.	Adj.Sig.
Pre Intervention-Post Intervention	-18.431	6.631	-2.779	.005	.016
Pre Intervention-30 Days Post Intervention	-23.038	7.324	-3.145	.002	.005
Post Intervention-30 Days Post Intervention	-4.607	7.324	-.629	.529	1.000

Each row tests the null hypothesis that the Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) are displayed. The significance level is .05.

**Independent-Samples Kruskal-Wallis Test**



<b>Total N</b>	97
<b>Test Statistic</b>	12.205
<b>Degrees of Freedom</b>	2
<b>Asymptotic Sig. (2-sided test)</b>	.002

1. The test statistic is adjusted for ties.

## **Appendix M**

### POST TEST

1. Would you like to receive additional training regarding bereavement care?
  - a. Yes
  - b. No
  
2. Did you find the training helpful?
  - a. Yes
  - b. No